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A Medicare Buy-In: Examining the Costs for Two Populations

by
Roland D. McDevitt, Ph.D.
Watson Wyatt Worldwide

The Public Policy Institute, formed in 1985, is part of the Research Group of the American Association of Retired Persons. One of the missions of the Institute is to foster research and analysis on public policy issues of interest to older Americans. This paper represents part of that effort.

The views expressed herein are for information, debate and discussion, and do not necessarily represent formal policies of the Association.

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Acknowledgments

Many people contributed their time and energy to think through the issues of pricing and adverse selection addressed in this report. Edwin Hustead of The Hay Group offered insights concerning administrative costs in commercial health plans. Several of my colleagues at Watson Wyatt, including Christopher George, Richard Murdock, Sylvester Schieber, and Mark White, read a draft of the report and furnished valuable comments. Lex Miller helped estimate monthly payments that result when a portion of premium payments are postponed into the future. In addition, Tim Waidmann of the Urban Institute and Jack Rodgers of Price Waterhouse provided helpful comments on a draft of the report. Laura Kirkland provided timely programming support throughout this project. Finally, Gerry Smolka of AARP facilitated access to a variety of information and data sources, and maintained a sense of humor throughout the project.

Although the contributions of each of these people enhanced the quality of the report, I am solely responsible for the assumptions, data analysis and interpretations. It should also be noted that the first draft of this report was completed before the Administration announced its buy-in proposal. Consequently, the estimates of premium costs presented in this report are independent of that proposal.

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Foreword

The American Association of Retired Persons (AARP) has long been concerned about the number of Americans without health insurance. One of the most vulnerable of the groups without insurance is comprised of persons just below the current Medicare eligibility age (age 62-64), who are more likely to require medical care than are younger persons. Permitting these individuals to "buy-in" to Medicare coverage is one approach to covering more of the uninsured, and the Clinton Administration and some members of Congress have recently proposed this option. In addition, during the debate surrounding the Balanced Budget Act of 1997, the idea of a "buy-in" for those age 65-66 emerged in the context of proposals to raise the age of Medicare eligibility to age 67.

While the concept of a Medicare "buy-in" has been receiving attention, almost no information has been widely available on the costs to individuals of purchasing Medicare coverage. To help fill this gap, AARP asked Watson Wyatt to answer the following basic questions about extending such an option to persons age 62-64 and 65-66:

- What are the costs of other health insurance options available to these individuals?

- What would it cost an individual to buy Medicare coverage at its full actuarial value, assuming widespread participation within the age group?

- What would it cost an individual to buy such coverage, assuming various levels of adverse selection?

The goal of the analysis was to accurately estimate the cost of purchasing Medicare coverage under an assumption that Medicare buy-in enrollees would need to pay their own way. Hence, Watson Wyatt took care to identify the full costs of a buy-in. Where assumptions were necessary to develop the cost estimates, they were generally made in a fashion that might overstate rather than understate actual costs.

While Watson Wyatt's analysis provides an important starting point for evaluating the cost of a buy-in option, it is a single point-in-time estimate in 1997 dollars. The analysis prompts a series of related policy questions worthy of future study:

- What are the implications of a buy-in option for those already covered by employer-based or individually purchased plans? Would employers change their retiree health benefits? Would individuals purchasing their own coverage find their options limited to the buy-in?

- How affordable would the buy-in premiums be for persons in different income groups for whom private coverage is unaffordable or unavailable due to their poor health?

- How might the cost to individuals change over time, either in the worst case, if adverse selection creates a death spiral, or in the best case, if very broad participation lowers premiums?

- How would a delay in the age of Medicare eligibility affect retirement decisions of individuals without employer-sponsored retiree health benefits, if a buy-in option were available?

- What issues might arise if individuals were permitted to pay for a portion of Medicare insurance costs *after* the insurance benefit was delivered? For example, when added to Part B premiums, would deferred premiums be affordable to an 80 year old woman who bought Medicare at age 62?

This project, which was initiated before the recent Administration and Congressional proposals were announced, was not intended to be an analysis of those proposals. Nor was it intended to be an examination of the range of policy issues, such as those identified above, related to a Medicare buy-in. Rather, its goal was to estimate the cost to individuals age 62-64 and age 65-66 of purchasing Medicare, and to stimulate discussion and debate on this important topic. We believe that Watson Wyatt's report lays the foundation for further discussion of key issues in assessing buy-in proposals.

Gerry Smolka
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Executive Summary

Purpose

This report explores some of the cost issues surrounding a Medicare buy-in. Specifically, it examines the costs of a buy-in for both the 62-64 age group and the 65-66 age group – those who have not yet reached the current age of Medicare eligibility, and those who would lose coverage if the eligibility age were raised to 67.

Background

Although Medicare affords considerable security to those age 65 and over, the picture is different for the near elderly. In 1995, about 14 percent of the 62-64 age group lacked health insurance. Near-elderly persons without health insurance could face severe financial consequences if they were to experience a hospital stay or other costly medical event. Many of these people are already retired, with limited incomes and assets, and such an event could threaten their financial security for the rest of their lives. One idea for extending coverage among members of this group is to allow them to purchase Medicare coverage.

Should the age of Medicare eligibility be raised to age 67, individuals in the 65-66 age group would find it at least as difficult to obtain private health insurance as those age 62-64. A buy-in option might provide a solution for at least some of these people.

Methodology

This report uses survey data from a number of sources to document the extent of health insurance coverage from various sources, and to estimate the health insurance premium costs currently paid by members of the 62-64 and 65-66 age groups. Medicare buy-in premiums are then estimated, using Medicare program data and alternative assumptions about selection bias. In developing these assumptions, Watson Wyatt considered the experience of employer-sponsored plans that must offer continuation coverage under the provisions of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985.

Results

The costs of health insurance available to the 62-64 age group in 1997 varied dramatically, depending upon individual circumstances. Those enrolled in employer-sponsored plans for workers paid an average of $420 per year toward the cost of their coverage. Others with COBRA continuation coverage paid an average of $2,142 for group coverage, and some who purchased individual commercial coverage paid as much as $16,000.

Within the 65-66 age group, those with Medicare and employer-sponsored retiree medical plans paid premiums averaging $1,126 per year, including the Medicare Part B premium. Those with Medicare and commercial Medigap coverage paid an average of $1,676. Although all of these people are “insured,” there is considerable variation in scope of

benefits and beneficiary cost-sharing, particularly for those insured in the commercial market.

This report estimates what Medicare buy-in premiums might have been in 1997 under alternative assumptions. **Buy-in premiums were estimated at $4,570 for the 62-64 age group, assuming that 20 percent of those who currently buy their own private coverage or who are uninsured would participate. Buy-in premiums were estimated at $5,041 for the 65-66 age group, assuming that 20 percent of this entire age group would participate.** Based on an examination of adverse selection under COBRA continuation coverage at this level of participation, similar levels of adverse selection were assumed. Higher levels of participation could mean less adverse selection and lower premiums. For example, **if 40 percent of the above groups were to participate in a buy-in, the premiums would be $4,149 for the younger group and $4,588 for the older group.**

Excluding Medicare enrollees with end stage renal disease, those dually eligible for Medicaid, and those in institutions, enrollees age 65 and older cost Medicare an average of $5,477 in 1997 — considerably more than the premiums estimated above for the two buy-in groups. The buy-in premiums are less because buy-in groups would be considerably younger than the average age of those who qualify on the basis of age. Another reason the premiums are less is that many of the sickest people in the buy-in age cohorts would have already qualified for Medicare benefits on the basis of disability.

Principal Findings

A buy-in program would represent an important insurance option for some people. Although Medicare's standard indemnity benefit is not as comprehensive as the typical plan employers offer to workers, the Medicare program offers enrollees considerable value in terms of low administrative costs, low provider fees, and limits on out-of-pocket spending for physician services. Medicare health maintenance organizations (HMOs), available to most individuals age 65 and older, offer both comprehensive benefits and good protection from out-of-pocket expense. The buy-in premiums estimated here, although high by the standards of employer-sponsored group health insurance, are considerably lower that what might otherwise be charged to buy-in candidates in the commercial market.

Introduction

The Medicare program covers the vast majority of Americans age 65 and over, and it furnishes the foundation for their medical coverage. About two-thirds of these individuals have private supplemental insurance to fill the gaps in Medicare coverage, and many others have Medicaid or other governmental health coverage to supplement Medicare. Less than 1 percent of the population age 65 and over is completely uninsured.

Although Medicare affords considerable security to those age 65 and over, the picture is different for the near elderly. In 1995, about 14 percent of the 62-64 age group was without any public or private health insurance.[1] This percentage is actually lower than for most other age groups, but this cohort faces higher risks than other age groups. First, individuals in this pre-Medicare group are more likely to require expensive medical care than younger adults. Second, many people age 62 through 64 are already retired with limited incomes and assets, or are approaching retirement. Catastrophic expenses at this time of life could permanently reduce the standard of living for these individuals and their spouses.

Many of these uninsured people do not choose to be uninsured, but are the victims of high insurance costs and underwriting practices that put health insurance beyond their reach. Proposals have been advanced to allow these older adults to purchase Medicare coverage as an alternative to private insurance. Some policy makers have opposed any such expansion of Medicare due to uncertainty over Medicare's future funding. Indeed, some policy makers have proposed raising the eligibility age from 65 to 67 in an effort to restrict enrollment and limit the cost of the program.

The Bipartisan Commission on Entitlement and Tax Reform recommended raising Medicare's eligibility age in its 1995 report, and it also proposed a Medicare buy-in option for those age 62 and older.[2] In 1997 the U.S. Senate adopted a measure that would have raised Medicare's eligibility age to 67 using the same time schedule in place for Social Security, but the Senate did not address the question of a Medicare buy-in. Even though the House of Representatives did not endorse this approach in 1997, the Senate action has placed the age of Medicare eligibility in the mainstream of the policy debate.

Since that time, President Clinton has advocated a Medicare buy-in for the 55-64 age group, and the National Bipartisan Commission on the Future of Medicare has been appointed to make recommendations for long-term Medicare reform, including the feasibility of allowing those between age 62 and the Medicare eligibility age to buy Medicare coverage. These developments suggest that the debate about Medicare's eligibility age, and the closely related issue of a Medicare buy-in, will be critical topics in the coming year.

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[1] 1995 Current Population Survey, Civilian Non-Institutional Population. March 1996.

[2] Bipartisan Commission on Entitlement and Tax Reform, J. Robert Kerrey, Chairman, and John C. Danforth, Vice-Chairman, 1995.

This report explores a number of issues associated with the costs of a Medicare buy-in proposal and the purchase of insurance under such a program. It considers both the 62-64 age group and the 65-66 age group – those who have not yet reached the current age of Medicare eligibility, and those who would lose coverage if the eligibility age were raised to 67. For these two age groups, we consider the following issues:

- Sources of current coverage,
- Premium costs of alternative sources of coverage,
- Medicare buy-in premiums that would result without adverse selection,
- Adverse selection and its effect on Medicare buy-in premiums, and
- The role a buy-in might play in making health insurance more affordable to seniors.

Current Sources of Coverage for Pre-65 and Post-65 Groups

Buy-in proposals have been advanced for both pre-65 and post-65 groups. This section examines the current sources of coverage for these groups in order to consider the likely appeal of a buy-in for each of them.

Pre-65 Groups

Employer-sponsored group health plans cover 60 percent of the 62-64 age-group, while 13 percent purchase individual coverage, and another 13 percent receive coverage from Medicare and other public programs (Table 1). The remaining 14 percent are uninsured. Employers typically pay most of the premium for active employee and early retiree plans, reducing the member's premium contribution. The premium cost for older participants, when they pay them, are further reduced by virtue of their health costs having been pooled together with those of younger workers.

Some of the individuals age 62-64 obtain employer-sponsored coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. COBRA mandates that employers allow employees and their dependents to continue coverage for periods of 18 to 36 months after a "qualifying event." Termination of employment for reasons other than "gross misconduct" is the most common qualifying event. Under these circumstances, the law provides for continuation coverage of up to 18 months. COBRA coverage is offered for 29 months to those who become disabled, and it is offered for 36 months to those who lose dependent coverage as a result of the employee's death, divorce, legal separation, loss of dependent child status, or entitlement to Medicare. The "entitlement to Medicare" provision is particularly important to the pre-65 spouses of older employees who lose their employment-based coverage upon retirement at age 65.

Former employees and other qualified beneficiaries who avail themselves of COBRA coverage typically pay 102 percent of the normal premiums for the plan, and the employer

seldom contributes.[3] This continuation coverage offers group premium rates that are generally attractive in comparison with individually purchased health insurance. It allows the former employee and qualified dependents to avoid any pre-existing condition clauses,

Table 1
Primary Source of Health Insurance:[1]
Pre-65 Population, 1995

(in millions)

Population by Age	Employer Plans	Other Private	Medicare	Other Public	Uninsured	Total
In Millions						
Under 65	152.3	11.8	2.8	25.5	40.3	232.7
Ages 62-64	3.5	0.7	0.4	0.3	0.8	5.7
Spouses of Persons Age 65 and Older						
Under 65	1.7	0.4	0.1	0.1	0.4	2.7
Ages 62-64	0.8	0.2	0.1	0.1	0.2	1.3
Percentages						
Under 65	65%	5%	1%	11%	17%	100%
Ages 62-64	60%	13%	7%	6%	14%	100%
Spouses of Persons Age 65 and Older						
Under 65	61%	16%	4%	5%	15%	100%
Ages 62-64	60%	18%	5%	4%	13%	100%

Source: Watson Wyatt Worldwide analysis of March 1996 Current Population Survey, Civilian Non-Institutional Population. This was the most current year for which population data were available to us at the time we began this study. Because the population counts and distributions change very little from year to year, the use of 1995 rather than 1997 population estimates does not have a material effect on our findings. However, private premiums and Medicare costs can change significantly from year to year, and we were fortunate to obtain 1997 cost and premium data from HCFA and other sources.

[1]People with more than one source of coverage are classified according to their primary source of coverage. We checked each person for coverage from each of the above categories, moving from left to right, and designated as "primary" the first category for which the person qualified. This generally reflects the coordination-of-benefits rules for the pre-65 population.

[3] The law allows employers to charge 150 percent of the normal premium to disabled qualified beneficiaries in months 19 through 29 of their coverage. Also, a small percentage of employers assist qualified beneficiaries in paying for their COBRA premiums. These COBRA provisions do not apply to employers of fewer than 20 employees

waiting periods, underwriting and changes in health care providers that might accompany an individually purchased plan.

The Current Population Survey (CPS) does not separately identify the COBRA component of employer-sponsored coverage, but the 1994 Health and Retirement Survey (HRS) allows identification of COBRA continuation coverage for the slightly younger age 58-62 cohort. For this cohort, just under 10 percent of those with employer-sponsored coverage obtained it through COBRA.[4] This would suggest that about 6 percent of the 62-64 age group (10 percent of the 60 percent with employer-sponsored plans) obtains coverage through COBRA.

Only 13 percent of the 62-64 age group purchases health insurance individually in the "other private" non-group market. Purchasing coverage individually carries a host of disadvantages not associated with the employer-sponsored plans. These disadvantages are discussed in the following section, Health Insurance Premium Costs.

Aside from employer-sponsored group plans and individually purchased policies, the most common source of coverage for the 62-64 age group is Medicare. The CPS indicates that 7 percent of this age group is enrolled in Medicare. These enrollees comprise a high-risk group that qualifies because of disability. Some of these enrollees also participate in the Medicaid program. For these people with dual eligibility, there is little if any cost-sharing, because Medicaid fills in the gaps in coverage left by Medicare.

Finally, 6 percent of the 62-64 age group is covered only through Medicaid and other public programs such as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the Veterans Administration, and government-sponsored clinics. Taken together with the Medicare group discussed above, this means that 13 percent of the 62-64 age group is already enrolled in government-sponsored plans. A high percentage of this government-sponsored group is disabled, and their costs are considerably higher than the overall 62-64 age group average.

According to CPS, 14 percent of the 62-64 age group had no health insurance during the 1995 calendar year. This is somewhat less than the 17 percent uninsured rate for the entire under-65 population, but the risks of going uninsured at this age are higher than for younger people. By virtue of their age, members of this older cohort are more likely to encounter serious health problems and the catastrophic health care expenses associated with these health problems. The idea behind buy-in proposals is that some of these uninsured individuals might gain better access to health care services if they were able to purchase Medicare coverage.

One group of particular interest to policy-makers is comprised of the pre-65 spouses of Medicare enrollees age 65 and older. Table 1 indicates there are 2.7 million people in this group, and about half of these individuals are in the 62-64 age group that might be offered a buy-in. The prevalence of insurance among these spouses is similar to the general pre-65

[4] Pamela Loprest and Cori Uccello, "Uninsured Older Adults: Implications for Changing Medicare Eligibility," The Commonwealth Fund, February, 1997, p.5.

population, but many spouses lose employer-sponsored coverage when the family head leaves active employment and enters the Medicare program.[5] Over 1 million (1.3 million) of these spouses would qualify if a Medicare buy-in option were offered to the 62-64 age group, but the majority of these people already have coverage through employer-sponsored group plans. About 200,000 of these spouses have no insurance, and might find the buy-in an important coverage option. For some spouses not yet 62, COBRA coverage followed by a Medicare buy-in might bridge the gap until they qualify for coverage by Medicare at age 65.

Groups 65 and Older

Medicare is the primary payer for 95 percent of the entire population of persons 65 and older (Table 2). Only 1 percent of seniors have no health insurance at all, and another 4 percent are covered as active workers or dependents under employer plans that remain the primary payer even when a plan member is enrolled in Medicare.

Table 2
Primary Source of Health Insurance:[1]
Population 65 and Older, 1995

(in millions)

Population by Age	Employer (Active)	Medicare/ Employer (Retiree)	Medicare/ Medigap	Medicare	Other Public Only	Uninsured	Total
In millions							
65 and over	1.4	9.7	10.6	9.6	0.0	.3	31.7
Ages 65-66	0.4	1.5	0.9	1.1	0.0	0.1	4.0
Percentages							
65 and over	4%	31%	34%	30%	0%	1%	100%
Ages 65-66	10%	38%	23%	27%	0%	2%	100%

Sources: Watson Wyatt Worldwide analysis of March 1996 Current Population Survey, Civilian Non-institutional Population; 1995 Medicare Current Beneficiary Survey. Estimates for active employee and retiree plans were developed by applying the proportions with active vs. retiree coverage, as estimated by the 1995 Medicare Current Beneficiary Survey, to the total employer-sponsored population in the March 1996 Current Population Survey.

[1]For the population age 65 and older, Medicare is normally the primary payer except for people covered by active employee plans. Consequently, Medicare is indicated as the primary payer for those with employer-sponsored retiree medical plans, those with Medigap plans, and those with Medicare and Medicaid or Medicare only.

Gaps in Medicare's benefit package, particularly the lack of prescription drug benefits and protection from catastrophic medical expense, mean that supplemental plans play an important role. Among the 95 percent of seniors with Medicare primary coverage, there is an almost equal division between those with employer-sponsored retiree medical plans (31

[5] Julia Lawlor, "Between Work and Medicare, a Health Gap," The New York Times, December 28, 1997.

percent), those with commercial Medigap plans (34 percent), and those with Medicare but no private supplemental plan (30 percent).[6]

Restricting our focus to seniors in the 65-66 age group who might lose coverage if the Medicare eligibility age were raised, 10 percent currently have primary coverage through an active employee plan, and another 38 percent have employer-sponsored retiree medical plans to supplement Medicare. But employers have been limiting their contributions to these retiree medical plans and even dropping them altogether. If Medicare's eligibility age were raised to 67 and these retiree plans became the primary payers for those now covered by Medicare, employers and individuals would face difficult decisions about how to pay the premium costs that are currently covered in major part through government spending.

Health Insurance Premium Costs

For both the pre-65 and 65-66 groups to whom a buy-in might be offered, premium costs will weigh heavily in their decisions whether or not to elect coverage. Whether they participate will depend on the price of a Medicare buy-in, the availability of other alternatives, and the cost of other alternatives. We start by looking at the cost of alternative sources of coverage today.

Pre-65 Premiums

Employer-sponsored group plan premiums for active employees averaged $2,100 per covered adult in 1997, with employees typically paying 20 percent of this amount and employers paying the remainder (Table 3). The average pre-65 retiree premium reported in Table 3 is $3,500, but this understates early retiree costs because some employers include these retirees in the same plan as active employees, and report only a single premium for both groups. These early retirees pay an average of 40 percent of the total premium, or $1,400 per year, but some pay far more.

COBRA premiums are generally attractive in comparison to those for individually purchased health plans (discussed below), but even this coverage averaged $2,142 per adult annually, all of which was paid by the beneficiary. Moreover, COBRA coverage is generally available only for periods of 18 to 36 months. COBRA furnishes a bridge between plans and is particularly useful to individuals who might experience lapses in coverage due to short periods of unemployment. COBRA offers the spouse and dependents the opportunity to retain employer-sponsored coverage for up to 36 months when the employee becomes entitled to Medicare, but COBRA is not a general solution to the problems of health insurance for retirees or for individuals who are unable to work for longer periods.

[6] According to the 1996 Current Population Survey, 26 percent of those with Medicare but no private supplemental plan did have additional coverage from other public programs, such as Medicaid. Medicare is generally primary to these programs.

Table 3
Private Insurance Premiums and Beneficiary Contributions:
Pre-65 Population, 1997

	Employer-Sponsored Plans			
	Active Employee[1]	**COBRA**[2]	**Pre-65 Retiree**[3]	**Other Private**[4]
Typical adult annual premium	$2,100	$2,142	$3,500	$2,000-$16,000
Typical share paid by beneficiary				
Percent	20%	100%	40%	100%
Amount	$420	$2,142	$1,400	$2,000-$16,000

Source: Watson Wyatt Worldwide.

[1]*The ECS Survey Report on Employee Benefits, 1997/98*, Watson Wyatt Data Services, Watson Wyatt Worldwide, 1997. For purposes of interpreting this premium and modeling benefits elsewhere in this report, we assume a comprehensive medical plan with a $250 annual deductible, 20 percent coinsurance, and an annual $1,500 out-of-pocket maximum. This design is representative of indemnity plans. Managed care plans have similar premiums but lower out-of-pocket costs. Of 621 employers reporting retiree medical benefits in the ECS Survey, 24 percent employed fewer than 250 workers, 30 percent employed 250-999 workers and 46 percent employed 1,000 or more workers.

[2]COBRA premium rates are 102 percent of active employee rates.

[3]*The ECS Survey Report on Employee Benefits, 1997/98*, Watson Wyatt Data Services, Watson Wyatt Worldwide, 1997. Note that the $3,500 average premium for early retirees does not reflect the full cost of early retirees, because some employers do not separate out the premium costs of actives and retirees. Also, early retiree coverage includes many people younger than the groups that are considered in the Medicare buy-in options addressed in this report.

[4]The low end of this range was calculated assuming that the individual is able to purchase a community rated plan that benefits from 30 percent favorable selection and has an administrative loss ratio of 30 percent. The high end of the range is a premium quote from a Los Angeles plan. This $16,000 annual premium for single coverage age 60-64 was subject to medical underwriting. It carried in-network plan provisions of a $250 deductible, 20 percent coinsurance and a $2,000 out-of-pocket maximum; and out-of-network provisions of a $1,000 deductible, 50 percent coinsurance, and a $5,000 out-of-pocket maximum. In fact, there is tremendous variation in plan design, cost-sharing provisions, degree of selection bias, and extent of age rating.

The principal source of coverage for those without access to employer-sponsored insurance is the individual or "other private" market (Table 3). Our research found annual premiums for a privately purchased comprehensive medical plan can vary tremendously, from $2,000 to $16,000. This variation reflects diversity in area-specific costs, rating practices, underwriting, and extent of favorable or adverse selection among the individual plans (see notes for Table 3).

In comparison with employer-sponsored group plans, pre-65 individuals seeking coverage in the individual market face multiple factors that can raise their premium costs and limit their access to insurance. First, insurance regulations in most states permit at least some degree of age rating. Based on age alone, insurers typically expect people age 60-64 to generate health care expenses of twice the average for the working population of all ages.

Second, people seeking to purchase individual insurance face the prospect of medical underwriting. Insurers might limit coverage for pre-existing conditions, charge higher premiums to individuals expected to generate higher costs due to chronic medical conditions, or deny coverage altogether to those who are most likely to require very costly medical care.

Finally, the administrative costs associated with marketing, underwriting, and other aspects of managing these individual policies are high, driving up premiums. A 1988 survey by Hay/Huggins found administrative costs represented about 30 percent of total premiums for individual policies.[7] A 1997 survey by Weiss Ratings, Inc. found that administrative costs accounted for about 40 percent of total premiums in the individual health insurance market[8]

While employer-sponsored health plans generally afford good financial protection in the form of relatively low deductibles, coinsurance and out-of-pocket maximums, the higher costs associated with the individual insurance market tend to result in less generous plans in an effort to keep the premiums affordable. There is no comprehensive national survey of health plan designs and premiums in the individual market, but plan deductibles as high as $2,500 are common.[9]

Premiums for Those 65 and Older

Most people age 65 and older are covered by both Medicare and a supplemental plan. Any discussion of premiums for this population is complicated by the diversity of plan designs, which afford different levels of financial protection to the beneficiary. For purposes of

[7] Hay/Huggins report for the Congressional Research Service, "Cost and Effects of Extending Health Insurance Coverage," *Library of Congress*, October 1988. The Hay/Huggins definition of "administration" included all non-claims expense.

[8] Weiss Ratings, Inc. surveyed companies writing health insurance in 1997. Weiss performed a special analysis of this database for this study. The non-claims portion of premiums was reported at 41 percent – more than 10 percentage points higher than the Hay/Huggins report of 9 years earlier.

[9] "Summary of Competitive Market Data for Insured Medical Products Available to Individuals Age 50 to 64," Market survey performed by William R. Mercer, Inc. for American Association of Retired Persons, July 1997.

comparison, we selected plan designs and cost-sharing arrangements that are common for each of the coverage groups compared. For active employee and retiree medical plans sponsored by employers, we assumed a standard comprehensive plan design with a $250 deductible, 80 percent coinsurance, and a $1,500 out-of-pocket maximum. For those with Medigap coverage we assumed standard plan F, which fills in the enrollee cost-sharing for Medicare-covered services but does not pay for prescription drugs.

Active employees age 65 and older covered by employers continue to enjoy the same level of premiums as younger employees, averaging $2,100 in 1997, with the employee paying an average of $420 or 20 percent of the total (Table 4).

The standard plan design for an employer-sponsored medical plan for retirees age 65 and older is a Medicare supplemental plan which fills in the principal gaps in acute medical care that Medicare does not reimburse – deductibles and coinsurance for Medicare-covered services, and prescription drugs which are not covered by Medicare. The plan was further assumed to include a carve-out arrangement for coordination of benefits.[10]

Watson Wyatt's PreView Medical Benefit Model was used to estimate the average out-of-pocket costs for Medicare enrollees in the 65-66 age group. (These costs are in addition to the premium costs presented in Table 4.) The model estimated out-of-pocket spending of about $600 for active employees, employer-sponsored retirees, and individuals with Medigap plan F.[11]

Although these average out-of-pocket costs are roughly similar across the three privately insured groups, the sources of expense and the levels of risk differ. Those with employer-sponsored plans typically enjoy comprehensive benefits, including prescription drugs, and an out-of-pocket maximum of $1,500. Medigap plan F, the most popular of all Medigap plans, pays the full remaining cost of Medicare-covered services, but pays nothing for prescription drugs.[12] The $600 in expected out-of-pocket costs associated with Plan F reflects the average level of prescription drug spending for the 65-66 age group. A relatively small percentage of this population actually spends an average of $600

[10] In a carve-out arrangement the secondary payer first calculates what it would have paid if it were primary, and then subtracts the payments made by the other payer, which is Medicare in this case.

[11] The out-of-pocket costs estimated here encompass the services typically covered in an employer-sponsored retiree medical plan, including prescription drug. These out-of-pocket estimates exclude premium payments for insurance, vision care, dental care, long-term care and over-the-counter medications.

[12] The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-108) limited Medigap plans to 10 standard designs in order to simplify plan comparisons for beneficiaries. Three of the designs, with 14 percent of the Medigap population, offer limited prescription drug benefits but the other 86 percent of policies sold are plans limited to filling in the deductibles and copayments for Medicare-covered services. (See Fox, Peter D, Thomas Rice, and Lisa Alecxih, "Medigap Regulation: Lessons for Healthcare Reform, " Journal of Health Politics, Policy and Law 20(1):31-48, Spring 1995.)

Table 4
Private Health Insurance Premiums and Beneficiary Contributions: Population 65 and Older, 1997

		Employer-Sponsored		Individual
		Active Employee[1]	Retiree 2nd to Medicare[2]	Medigap (Plan F)[3]
Typical adult premium		$2,100	$1,500	$1,150
Beneficiary contribution	Percent	20%	40%	100%
	Amount	$420	$600	$1,150
Medicare premium (Part B)[4]		--	$526	$526
Total beneficiary contributions		$420	$1,126	$1,676

Source: Watson Wyatt Worldwide.

[1] See note 1 from Table 3.

[2]The ECS Survey Report on Employee Benefits 1997/98 Watson Wyatt Data Services, 1997. Note this average premium is lower than the average cost of early retirees, because these retirees are sometimes pooled with active employees. When this occurs, plans report a plan premium that includes both active employees and early retirees.

[3] Medigap premiums averaging just over $1,000 were reported in the 1995 Medicare Current Beneficiary Survey conducted by the Health Care Financing Administration. We dropped all annual premiums of less than $250 on the assumption that these were not Medigap plans, and we characterized the result as representing Medigap plan F, the most prevalent Medigap plan. We then trended the premium forward to 1997 using an annual rate of increase of 7 percent, reflecting the recent experience of the Medicare program. Plan F fills in the enrollee cost-sharing for Medicare-covered services, but does not pay for prescription drugs.

[4] Medicare premiums were $43.80 per month in 1997 and remained at that level for 1998. This totals $525.60 for 12 months and represents about 25 percent of the average Part B program expense, and just under 10 percent of total Part A and Part B program expense for 1997.

on drugs, but a small number of very high users experience costs that far exceed this level. Therefore, some Medicare beneficiaries with Medigap plan F experience catastrophic out-of-pocket spending despite health insurance coverage through both Medicare and Medigap.

Table 4 also presents an estimate of average total beneficiary premium contributions in the three private insurance arrangements. Those with plan F spend $1,676 per year, including Medicare and Medigap premiums. Those with employer-sponsored retiree medical plans average over $1,126 each year and have the peace of mind that comes with prescription drug benefits. Those with active employee coverage average $420 per year.

About 10 percent of the population age 65 and older has neither private supplemental coverage nor any coverage through governmental programs other than Medicare. This "Medicare only" group pays insurance premiums of only $526 per year for Part B

coverage, but all charges not paid by Medicare are the responsibility of the individual. Some individuals in this "Medicare only" group are enrolled in Medicare risk contracts.

For these and other Medicare beneficiaries, HMOs available through Medicare represent an increasingly important alternative, because these HMOs offer comprehensive coverage with very low out-of-pocket costs.[13] About 70 percent of the population age 65 and older now live in zip codes served by at least one Medicare risk HMO, and 60 percent live in zip codes with 2 or more risk product offerings. Most of these plans offer at least limited coverage for prescription drugs. In addition, most of these managed care plans do not require a premium payment beyond the standard annual Part B premium of $526. When additional premiums are required for these plans, they are generally less than $50 per month.[14]

Buy-In Premiums Without Adverse Selection

Having described the current premium costs and sources of coverage for the pre-65 and 65 and older populations, we now address the premium costs that might result from a Medicare buy-in policy designed to charge buy-in groups the full actuarial value of the benefits delivered.

To estimate premiums for the 62-64 and 65-66 age groups, we used rating factors developed by the Health Care Financing Administration (HCFA) for use in calculating payments to Medicare risk HMOs. The starting point is HCFA's United States per Capita Cost (USPCC) for Aged Medicare enrollees. According to HCFA's September 1997 USPCC rates, Medicare spent an average of $5,477 per Medicare enrollee age 65 and older during the 1997 calendar year.[15]

We used this average expenditure together with HCFA Demographic Factors (see Methodology Appendix) to calculate age-specific rates for persons 65 and older who are not enrolled in Medicaid, not residing in an institution, and not receiving treatment for End Stage Renal Disease (ESRD). These excluded groups tend to cost the program considerably more on a per-capita basis than the aged non-institutional group upon which our calculation is based. The Demographic Factors allowed us to estimate both age-specific rates for the post-65 population and the increase in costs as enrollees grow older.[16] Using this information, we were able to estimate the age-specific premiums for the two potential buy-in age groups: 62-64 and 65-66.

Without considering adverse selection, we estimated Medicare buy-in premiums of $3,044

[13] Many of these HMOs limit the prescription drug benefits to $1,000 or less per year, and some do not cover prescription drugs. Still, most of these HMOs offer at least some drug benefit along with very low levels of beneficiary cost sharing for Medicare covered services.
[14] These statistics were developed from data on HCFA's Web site (www.hcfa.gov), November 1997.
[15] The USPCC Rates and Demographic Factors used in this analysis are from HCFA's September 1997 rate announcements, and were taken from the HCFA Web site at (www.hcfa.gov). The USPCC rates include all Medicare benefit payments as well as private sector administrative costs incurred by Part A Fiscal Intermediaries and Part B Carriers. The USPCC rate used here is for the Aged enrollees, and does not include those receiving ESRD services. They do not include administrative costs for HCFA staff.
[16] Ibid. See also the discussion in the Methodology Appendix.

for the 62-64 age group and $3,358 for the 65-66 age group (Table 5). Both of these rates are considerably below the average for the entire population age 65 and older, because medical spending tends to increase markedly with age. Table 5 also presents estimates for age-rated Medigap plan F premiums for the two buy-in groups. We estimate Medigap premiums of $780 per year for the 62-64 age group and $840 for the 65-66 group, compared with $1,150 for the entire Medigap population age 65 and older.

The Medicare buy-in premiums presented in Table 5 reflect *favorable selection* that would result for a potential buy-in program, because certain high-cost groups are already in Medicare and would not be candidates for a buy-in. One high-cost group that would retain full Medicare eligibility is the disabled population. Prior to age 65, disabled individuals qualify for Medicare under a specific eligibility criteria. Upon reaching age 65 these individuals are reclassified as "aged," but they would still qualify for Medicare if the eligibility age were

Table 5
1997 Medicare and Medigap Premiums:
Age-Adjusted Estimates
(without adverse selection)

	Age Group		
	Persons 65 and older	**Buy-In Age 65-66**	**Buy-In Age 62-64**
Medicare Premium Equivalent	$5,477	$3,358	$3,044
Enrollee share	$526 (9.6%)	$3,358 (100%)	$3,044 (100%)
Medigap plan F[1]	$1,150	$840	$780
Total annual premium	$1,676	$4,198	$3,824

Source: Watson Wyatt Worldwide estimates.

See notes for previous tables, text footnotes 13 and 15, and the Methodology Appendix.

[1] The Medigap plan F premium for persons 65 and older is developed from analysis of the 1995 Medicare Current Beneficiary Survey as discussed previously. The age-specific rates in the last two columns are developed from HCFA Demographic Factors.

raised to 67. Medicare's Demographic Factors do not allow us to explicitly identify the costs of these older disabled individuals, but there are Demographic Factors for other high cost groups age 65 and older.

These other high cost groups include dual Medicaid/Medicare enrollees, those who are institutionalized, and ESRD aged enrollees. For the most part, individuals in these high cost groups would continue to quality for Medicare as disabled, and many of those who did not qualify as disabled would continue to receive comprehensive coverage through the

Medicaid program.

Buy-In Premiums with Adverse Selection

Economic theory and actual experience in insurance markets suggest that many individuals will voluntarily purchase insurance only when they perceive a relatively high probability that their medical expense will exceed their premiums. Moreover, at least some individuals who would consider buy-in coverage have alternative opportunities to purchase insurance in the private market. Given current underwriting practices in this market, people with costly and chronic medical conditions are least likely to obtain private insurance, leaving them as stronger candidates for the buy-in program.

In assessing the likely effects of adverse selection on premiums, there are two critical factors that must be considered. First, we must consider the expense of those who would buy-in relative to those who are already participating in Medicare's program for the aged. The analysis that follows suggests that, even after adverse selection, the buy-in premiums would be less than average per-capita expenditures for all Medicare enrollees age 65 and over.

Second, we must consider the potential size of the buy-in population. The potential for adverse selection is greatest when only a small percentage of individuals offered coverage, those with the highest costs, elect to purchase it. This report estimates premiums for a buy-in program in which participants pay the full cost of their own coverage.

Relative Expense of Buy-In Groups

The COBRA legislation described earlier in this report has created an opportunity for adverse selection that is similar, in many respects, to the situation that would exist under a Medicare buy-in. Under COBRA, qualified beneficiaries can buy continuation coverage with their active employee plan, or accept alternative offerings that might be available elsewhere. Most qualified beneficiaries decline COBRA coverage. This commonly happens when the employee accepts employment with another company that offers health benefits.

Over the past 5 years about 20 percent of qualified COBRA beneficiaries have accepted continuation coverage. Their plan costs during this period, including administration, varied from 148 to 156 percent but averaged 150 percent of the costs for active employees.[17] What is most noteworthy about this experience is that, despite the potential for adverse selection, many people who purchase COBRA continuation coverage incur medical expenses far below the level they are spending on premiums. It is difficult for individuals to predict with any precision the level of medical expense that will occur in the coming year, but many people have enough aversion to risk that they are willing to pay substantial premiums for the peace of mind that goes with insurance.

[17] Spencer's Research Reports, "1997 COBRA Survey: More Than One in Four Elect Coverage, Cost Is 156% of Active Employee Cost," (329.04.-1), August 22, 1997.

Effective communications and ease of enrollment are two factors that ameliorate the extent of adverse selection with COBRA. The availability of COBRA coverage is widely known, and federal laws and regulations are intended to ensure that those who experience a qualifying event are promptly notified of their COBRA rights. Those who wish to continue their coverage simply notify the employer. There is no question of eligibility, no need to take a physical examination or fill out detailed questionnaires, and no need to comparison shop for premiums and benefit design. In short, people who qualify know they qualify, they know it is easy to continue enrollment, and they know what their premium will be. These conditions make COBRA coverage attractive not only to the highest risk individuals, but also to many others who need to replace their employer-subsidized plan.

If the COBRA experience is transferable to the Medicare buy-in, we might anticipate adverse selection as depicted in Figure 1. For example, if only 20 percent of those not covered by employer plans or government health programs elected to purchase it, we would expect purchasers to cost the program 150 percent of their age-rated premium ($4,570 rather than the overall group average of $3,044 for those age 62-64). If a larger proportion of the eligible group purchases coverage, we would see the costs of the buy-in group converge with anticipated age-rated costs for the entire group. The premium costs for 62-64 year olds would drop to $4,159 with 40 percent of the group purchasing coverage, and would drop further to $3,387 with 80 percent of the group purchasing coverage. Figure 1 illustrates a similar pattern of adverse selection for the 65-66 age group.[18]

While adverse selection would undoubtedly occur in a buy-in program, some of the highest risk groups are already participating in Medicare and will continue to participate in the future. Over 12 percent of current Medicare enrollees qualify as disabled, and some of these incur very high medical expense year after year. Under the current system, disabled enrollees are reclassified as aged upon reaching age 65; such enrollees would still qualify as disabled if the standard eligibility age were raised to 67.

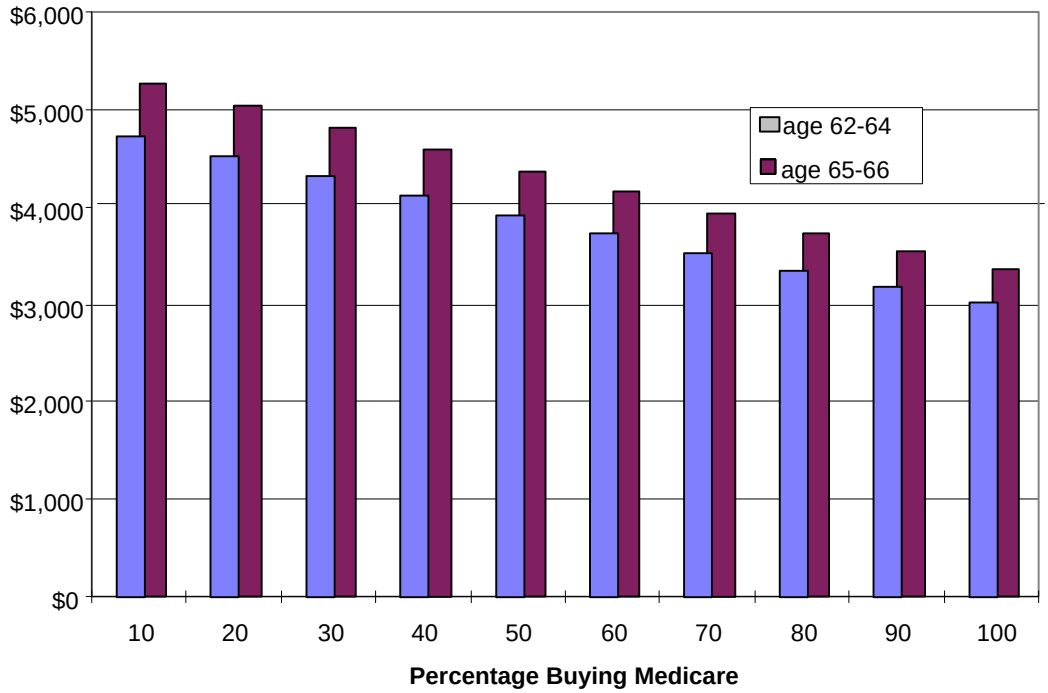
Potential Size of the Buy-In Populations

Population estimates from 1995 indicated nearly 6 million people in the 62-64 age group, and 4 million in the 65-66 age group (Tables 1 and 2).[19] We consider the two buy-in groups separately, beginning with those 62-64.

[18] These premium levels may be somewhat overstated because some disabled persons, whose costs are higher than the average for others of the same age, are included in the base rates used to calculate these premiums. In actuality, these persons would retain eligibility for Medicare's program for disabled persons.

[19] As noted in Table 1, 1997 population estimates which would correspond with our 1997 premium estimates are not yet available. The relative sizes of the sub-populations covered by each category of health insurance change very little over a two-year period.

Figure 1
Illustrative 1997 Premiums at Differing Buy-In Participation Levels



Source: Watson Wyatt Worldwide.

The age rated premiums appearing in the columns to the right (100 percent of group buying Medicare) were calculated by Watson Wyatt using methodology discussed in the text and Methodology Appendix. The extent of adverse selection at other levels of market penetration were modeled to parallel the experience of employer-sponsored health plans that are required to offer continuation coverage under the provisions of the Consolidated Omnibus Reconciliation Act of 1985.

It may appear that nearly 6 million people in the 62-64 age group constitute a large potential buy-in population, but the great majority of these people already have insurance that is less costly than our estimated premiums under a Medicare buy-in (Table 6). Almost 3.5 million have employer-sponsored insurance which offers not only group rates, but also substantial premium contributions from employers. Another 0.7 million people have Medicare disability coverage or coverage through public programs such as Medicaid. The two groups with likely candidates for buy-in coverage are the "other private" group with 0.7 million people and the "uninsured" group with 0.8 million people. If 20 percent of each of these two groups were to elect Medicare buy-in coverage, this would produce 300,000 new Medicare enrollees with a premium estimated at 150 percent of the age-adjusted rate.

Putting this age 62-64 buy-in group in perspective, these 300,000 new Medicare participants would add less than 1 percent to the total number of Medicare participants. Moreover, the $4,570 anticipated premium costs for this adversely selected group (150 percent of the age-adjusted rate) is well below the overall average program expense of $5,477 for beneficiaries age 65 and older (Table 7).

If 40 percent rather than 20 percent of the other private and uninsured groups were to elect coverage under a buy-in, we would have 600,000 new enrollees and the average cost for the group would drop to $4,159 as was illustrated in Figure 1.

The story for the age 65-66 buy-in is more complicated. It is very difficult to predict what election patterns might occur within the 65-66 age group, because raising the Medicare eligibility age would change the basic premise upon which employer-sponsored retiree medical plans are based. If employers were to find themselves as the primary payers for the 65-66 age group, it is reasonable to assume that many would drop their

Table 6
Buy-In Elections of 62-64 Age Group, and Effects on Medicare Aged Population Enrollment[1]

(in millions)

	Employer-Sponsored	Other Private	Medicare	Other Public	Uninsured	Total
Current Coverage	3.5	0.7	.04	0.3	0.8	5.7
Lower Participation						
Buy-in percent		20%			20%	
Buy-in population		0.14			0.16	0.3
Higher Participation						
Buy-in percent		40%			40%	
Buy-in population		0.28			0.32	0.6

Source: Watson Wyatt Worldwide.

[1] We assumed that people age 62-64 with employer-sponsored coverage, those with other public coverage, and those already enrolled in Medicare would not elect to participate in a Medicare Buy-in. For the other two groups, we calculated the buy-in populations that would result from 20 percent and 40 percent participation levels. As noted in Table 1, the population estimates are for 1995 and would be slightly higher if available for 1997.

Table 7
1997 Age-Adjusted Medicare Premiums
With and Without Adverse Selection

Participation Rate	Medicare Population 65 and over	Ages 65-66	Ages 62-64
100%	$5,477	$3,358	$3,044
80%	NA	$3,737	$3,387
40%	NA	$4,588	$4,159
20%	NA	$5,041	$4,570

Source: Watson Wyatt Worldwide.

Note: There is no adverse selection with 100 percent participation, and the extent of adverse selection diminishes as participation rates rise. Relatively low participation rates would result from a program in which participants paid the full actuarial cost of a Medicare buy-in program. Subsidies would increase participation rates, and lower the extent of adverse selection.

retiree plans, move to defined contribution arrangements, or otherwise limit their financial liability for these plans.

The behavior of employees in the 65-66 age group might also change. Some employees might extend their working careers in order to retain the health insurance available to active employees. Others without an employer-sponsored retiree medical plan might find that a Medicare buy-in option would make retirement feasible even without an employer-sponsored plan.

Given the unpredictability of these events, we assumed that 20 percent of the entire 65-66 age group would elect to participate in a Medicare buy-in, and adverse selection would produce an average cost for this buy-in group 50 percent higher than would be expected for the entire age cohort. Under this scenario, the Medicare premium for the age 65-66 buy-in group would rise from $3,358 to $5,041 (Table 7). If 40 percent rather than 20 percent of this age cohort participated in a buy-in program, the premium would drop by $450 to $4,588.

The Role a Medicare Buy-In Might Play

Even with substantial adverse selection against the Medicare plan, a buy-in program that required participants to pay the full cost of their care could cost them less than Medicare's average expenditures for persons 65 and older, which were $5,477 per enrollee in 1997. Assuming substantial adverse selection, this report estimates buy-in premiums of $4,570 for persons age 62-64 and $5,041 for age 65-66. Annual premiums on the order of $4,500 to $5,000 are formidable to many retirees, and the standard Medicare benefit leaves substantial gaps in coverage.

Buy-in participants might spend additional money on Medigap supplemental plans, or they might opt for Medicare risk HMOs, which are growing rapidly from a modest base of 13 percent. Risk HMOs currently offer comprehensive benefits, and most do not require additional premium payments beyond those required by Medicare, although there is some

evidence that the scope of HMO benefits is narrowing and premiums are rising as Medicare limits its payments to HMOs.

The buy-in option described in this report might have considerable appeal to older Americans who cannot obtain affordable insurance from commercial sources. A buy-in option would ensure that all persons age 62 and over have at least one insurance alternative that will not deny them coverage, or impose pre-existing condition limitations. A Medicare buy-in option would also offer the price advantages of provider discounts that are generally greater than those enjoyed by other payers. Finally, Medicare's administrative costs of 2 percent are very low by comparison with private plans, although they would likely rise somewhat in an environment of greater consumer choice implied by the buy-in proposal.

The COBRA experience has been used to illustrate the extent of adverse selection that might result in a voluntary system. One lesson of COBRA is that effective communication and ease of enrollment are key elements in limiting the extent of adverse selection against a plan that cannot reject applicants or charge higher premiums based on measures of health risk. If Medicare were to allow a buy-in, it would be important that the communication and enrollment processes be structured in a way that would appeal to the widest possible group of people, rather than just those facing catastrophic expenses. Our simulation of adverse selection suggests that participation beyond the 20 percent level could greatly reduce premiums, as adverse selection is diminished through broader participation.

The concept of a deferred premium, which would spread some of the costs over the expected lifetime of a beneficiary, has been proposed as a way to make the high costs of a buy-in more affordable. The Administration and some members of Congress recently proposed such a deferred premium. Prior to age 65, beneficiaries would pay a lower premium than if they paid the full costs of the buy-in. This premium would reflect the actuarial costs associated with full participation in the program. After age 65, beneficiaries would pay a deferred premium that reflects the costs of adverse selection.

Using this report's 1997 buy-in premiums as a baseline (Table 7), we estimated 1999 buy-in premiums under the arrangement in the recent Administration and Congressional proposals. We estimate that an individual purchasing coverage in 1999 at age 62 would pay a monthly premium of $276, and a deferred premium of $55[20] per month upon reaching age 65. These premiums assume that the individual would enroll continuously for three years (age 62 through 64), that the beneficiary would be charged 6 percent interest on the deferred premium, that Medicare costs would rise 7 percent each year during this period, and that 20 percent of the target population would participate in the buy-in program. This premium would be in addition to the Part B premium.

This concept of deferred payment for a portion of the premium raises several policy issues. First, policy makers would need to determine what portion of the premium should be deferred and what portion should be paid at the time coverage is provided. Second,

[20] The full premium in 1999, assuming a degree of adverse selection associated with 20 percent, would be $414 per month for age 62-64.

interest rates might rise far above the 6 percent annual rate that we assumed for the above illustration. Higher interest rates might mean that the deferred portion of premiums could produce far more substantial payments for future cohorts of buy-in participants. Third, the deferred premium payments could grow even more if the eligibility age for Medicare were raised to age 67, and individuals were buying-in to the program for the full five-year period from age 62 through age 66.

Clearly a buy-in program would not adequately address the needs of all individuals in the targeted age groups. Three in five people age 62-64 are already covered by employer-sponsored group plans which offer both group-rated premiums and substantial premium contributions by the employer. For active employee plans, the average employee contribution of $420 per year is less than 10 percent of the buy-in premium estimated in this report. For those in pre-65 retiree plans, the average retiree contribution of $1,400 is less than one-third of the buy-in premium. Even COBRA coverage, where the individual pays the full premium with no employer contribution, would cost less than half of the amount that would be charged for Medicare buy-in coverage.

Although many individuals might find better health insurance options through employer-sponsored plans or even through the commercial market, a Medicare buy-in program could represent an important insurance option for some people. The buy-in premiums estimated here, although high by the standards of employer-sponsored group health insurance, are considerably lower than what is currently charged by many commercial health plans. Moreover, a buy-in program would ensure that at least one health insurance option is available to all people in the targeted age groups.

Methodology Appendix

This Appendix summarizes the methodology and assumptions behind our estimated Medicare buy-in premiums. In developing these premium estimates, we considered the following elements:

- Current "premium equivalents" for the Medicare population age 65 and older,
- Age of the potential buy-in populations,
- Relative costs of subpopulations already participating in Medicare (and therefore not buy-in candidates), and
- Adverse selection that might occur in a voluntary buy-in program.

Medicare "Premium Equivalents"

Each year the Health Care Financing Administration (HCFA) estimates the per-capita costs (including Parts A and B) of Medicare Aged, Disabled, and End Stage Renal Disease (ESRD) enrollees. These population-specific costs, or U.S. per Capita Costs (USPCCs), are used as a component of the rate formula by which Medicare pays risk HMOs. The Medicare buy-in premium estimates developed for this report began with the 1997 USPCC rate for the Aged population, which was $5,477 in 1997.

Age of Buy-In Populations

Per-capita medical spending increases substantially with age, and the buy-in populations examined in this study are considerably younger than the average for the current Medicare population. Consequently, the USPCC rate discussed above was adjusted for the ages of interest to this study – age 62-64 and age 65-66.

To make these age adjustments, we used another component of HCFA's Medicare risk HMO reimbursement formula – the Demographic Factors. HCFA uses separate Demographic Factors for categories defined by age and sex, institutional status, Medicaid status, and whether the enrollee is also covered by an employer-sponsored plan that is primary payer. We used the Aged USPCC together with Aged Demographic Factors for age 65-69 and 70-74. The age 65-69 calculation gave us an estimate close to the ages of interest to this study, and the rate of increase in costs between the 65-69 and 70-74 age groups guided further age adjustments.

The Demographic Factors indicate that, in moving from age 72 to age 67, costs fall by 4.35 percent for each year. We extrapolated this trend below age 67, but assumed that costs fall by only 3.85 percent for each year younger than age 67. This produced somewhat higher premiums estimates for the buy-in groups than would have resulted from a straight extrapolation of the cost curve from ages 72 to 67.

Relative Costs of Subpopulations

The Demographic Factors discussed above take into account not only age, but also additional enrollee characteristics that are highly predictive of medical cost. These characteristics include indicators of whether the individual is institutionalized and whether the individual is enrolled in the Medicaid program. By using the Demographic Factors for the non-Medicaid, non-institutional population, we have assumed that Medicaid enrollees and institutionalized persons would not be candidates for a Medicare buy-in.[21] Medicaid enrollees would have neither the need nor the means to purchase coverage; and many of those institutionalized people who do not receive Medicaid are likely to qualify for Medicare as disabled.

It would be desirable to exclude the costs of all disabled individuals from the calculation of buy-in premiums – not just those who are institutionalized or participating in Medicaid. About 12 percent of the current Medicare population is younger than age 65, and qualifies because of disabilities. These persons are relatively costly in comparison to other people of similar age, and they would retain eligibility for Medicare whether the normal age of Medicare eligibility were to remain at 65 or be raised to 67. Once disabled enrollees reach age 65, they are reclassified as aged, and Medicare no longer tracks them under a separate eligibility category.

Because our buy-in premium estimates are based on HCFA USPCCs and Demographic Factors for the aged population, we were not able to remove the costs of the entire disabled population. Consequently, the age-adjusted rates prior to adverse selection (see Table 5) are over-estimated.

Adverse Selection

The USPCC rates and Demographic Factors discussed above explicitly consider several sources of *favorable selection* that would tend to lower the premiums for a Medicare buy-in program. Within the population of people who are candidates for a Medicare buy-in, we would anticipate that high-cost individuals are more likely to elect to participate than low-cost individuals.

In order to better understand this potential for adverse selection, we examined the historical experience of the COBRA program, under which employers are required to offer continuation coverage to certain qualified beneficiaries. In that environment, qualified beneficiaries are given a choice of purchasing continuation coverage at 102 percent of the overall group rate, purchasing coverage elsewhere if it is available, or declining coverage altogether. This voluntary enrollment system is similar in key respects to the voluntary system contemplated for a Medicare buy-in. We therefore anticipate similar levels of adverse selection in the two settings.

[21] Individuals receiving treatment for ESRD are also excluded. ESRD enrollees are given a separate USPCC that is not adjusted with Demographic Factors.

The COBRA experience over the past 5 years indicates that about 20 percent of qualified beneficiaries offered coverage elect to take it, and those who elect this coverage cost the plan 150 percent of the overall group average cost. Using the historical COBRA experience with adverse selection, we developed a simulation of the adverse selection that might result from various levels of Medicare buy-in participation.

This simulation was based on the following assumptions. First, if all buy-in candidates purchased coverage, there would be no adverse selection. Second, if 20 percent were to purchase coverage, we might expect adverse selection to drive up costs by 50 percent, as demonstrated by the COBRA experience. Using these "benchmarks," we divided the potential buy-in population into two groups: a high-cost group with annual costs averaging over $40,000, and a low-cost group with costs averaging about $1,500. We then selected "enrollees" from the two groups such that high-cost individuals represent a higher proportion of enrollees at lower levels of participation, but additional low-cost individuals tend to average out the costs as participation becomes more widespread. We benchmarked the simulation to ensure that a 20 percent level of participation produced additional costs of 50 percent from adverse selection, as experienced with COBRA continuation coverage.

The results of this simulation (see Figure 1 and Table 7) indicated two things. First, even at low levels of participation (20 percent or less), there are many lower cost individuals who are likely to enroll and experience costs less than the amount of the premium. Second, as participation becomes more widespread, the premium rate drops significantly. Consequently, extensive participation in the buy-in program would tend to lower the premium rates used for purposes of discussion in this report.

These estimates are static in the sense that they do not consider the "death spiral" that might occur if lower cost individuals perceive rates are too high for the value Medicare coverage offers. Under a death spiral scenario, lower cost individuals would drop coverage as premiums increase, thereby driving up the average cost experience of the remaining group. In order to cover medical expense, the program would again raise premiums, thereby leading additional low-cost persons to drop coverage.

While the threat of a death spiral is real, there are several factors that might lead lower-cost enrollees to perceive value in a Medicare offering. First, a very high percentage of Medicare spending has historically gone to pay for medical care (administrative and marketing costs are low). Second, Medicare's market power allows it to pay providers at rates lower than most commercial payers, while still maintaining widespread provider participation. Third, Medicare has effectively protected enrollees from extensive balance billing in its fee-for-service program, and its managed care offerings provide good protection against out-of-pocket spending. Fourth, effective communications and streamlined enrollment procedures (as discussed in the text) might encourage many lower-cost individuals to participate in the program, thereby lowering the average cost of individuals in the group.